



# California's Health

PUBLIC HEALTH  
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Vol. 18, No. 9 • Published twice monthly • November 1, 1960

## SOME THOUGHTS ON THE FUTURE OF HOSPITALS\*

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In discussing the future of hospitals, we must accept the fact that where we are going depends in part on hospitals, but not in large part. The role of the hospital in a community is determined to a great extent by factors operating outside the hospital itself, beyond the control of physicians, administrators and Boards of Trustees. Some of the factors are: interaction of other community agencies on the hospital; basic influences that affect the community in general, such as recession or inflation; population shifts; war; changes in the birth and death rates, etc. Both the immediate and the more general factors affecting the role of the hospital in the community determine what kind of patients are admitted to the hospital and what the needs of the patient are.

To determine, therefore, where we are going, we must analyze the needs of the patient, now and in the future, and we must recognize that in the final analysis it is the public who will determine what the hospital's future is to be. It is the public who will decide what services it wishes us to provide, what relationship shall exist between hospital, physician and patient, and what legislation is required to bring about this relationship. It is our responsibility to provide leadership, analyze needs, recommend methods to meet those needs, and then to try to guide the public into making the wisest choice.

### Needs of the Individual

We all know that the needs of the individual can be stated quite simply: medical care, both preventive and curative, of a high quality at a price he can afford, and protection against

loss of income during illness. Whether he gets this care or not, or even whether it is available to him, is much more complicated. This depends first on the patient's ability to recognize what he needs, and his willingness to obtain it. Secondly, whether he receives the medical care he needs depends on whether it is available with qualified personnel, adequate facilities, an organization that permits the effective functioning that will speed the return of the ill person to health, and whether this can be provided at a cost the patient can afford.

At the present time, a typical patient may be subjected to one of two extremes: he may be seen by six or seven professionals in the medical and allied sciences, who may communicate with him, and who may or may not communicate with each other; or he may be left entirely to his own devices at a time when he has none. We all have in our hospitals people who should not have come there in the first place, and who have stayed too long, and we know that there are many people who should have been hospitalized, but who were not.

We must learn to be concerned with the care of the patient not simply as a patient in a hospital bed, but as an individual with a family who needs to be helped to avail himself of preventive services, of family service agencies, of community mental health services, of housekeeping services for his wife, of homes for his aging parents, of rehabilitative services, and of all the other community services that can and should be available to families when they are needed.

### Integrated Services

One of our main objectives should be to obtain rational, integrated services for the patient when these are indicated. This will not be easy to accomplish. Voluntary health insurance, and its tremendous growth in the United States in the past ten years, has contributed immeasurably toward this goal, but we need even more coverage than is presently available. The most efficient form of medical care, and the least costly in the long run, is preventive care, and prepaid insurance should cover the patient vertically as well as horizontally. The aim should be to keep the patient out of the hospital, not force him into it. Yet all this must be provided at a reasonable cost, which means that all forms of medical care must be more efficiently organized than they are today.

I think that group practice may well be worthy of consideration as one of the answers. It is interesting to speculate whether small groups of physicians, organized in professional competition with each other, physically located close to a common hospital and accepting patients on a prepayment basis, would produce both lower rates and better medical care. I believe they might, and that such an arrangement, or something similar, will be common in the not-too-distant future.

### Relationship to Medical Education

Another aspect of hospitals that must necessarily be modified is their

\* Presented at the Annual Meeting of Administrators of Crippled Children Services, Pleasanton, May 5, 1960.

relationship to medical education. In our system of training physicians, the voluntary hospital is an essential component of medical education, but this imposes a financial burden that it is becoming increasingly difficult to meet. Teaching on private patients has been moderately successful, but we still need large numbers of clinic patients, especially in obstetrics and the surgical specialties. Not only are the number of clinic patients dwindling because of health insurance, but also those clinic patients still available represent a major cost item to the hospital. Funds from communal agencies become less adequate each year; yet the treatment of all indigent patients in county or city institutions defeats the purpose of the medical education program in the voluntary hospital and could pose a real threat to the numbers and quality of available physicians in future years. Ways must be found of reducing the cost of the free work in voluntary hospitals and at the same time of assuring sufficient patients for a worth-while teaching program. Tax support may be part of the answer, but here again we must realize that this is a shifting of sources of revenue with a corresponding increase in overhead costs. It would be more effective to consider a plan for local governmental purchase of hospitalization insurance for the medically indigent, perhaps in conjunction with communal fund-raising agencies, to the end that the hospitals may receive their costs of caring for these patients.

It may be that this is impractical and that a critical reappraisal of our medical education program is necessary. Perhaps we should be training our physicians by the preceptorship method rather than the more organized, although relatively informal, hospital residency and internship program.

#### Care of the Long-Term Patient

Changes in medical education will obviously be slower in arrival than changes in nursing education, for example, but they must be thought about, and it is not too early to do so now.

We speak rather glibly, in the hospital field, of the hospital's being the center of the medical wheel of services, and of its being a "general" hospital. Fortunately, the trend now seems to

be in the direction of placing acutely ill patients of all types within the walls of the general hospital. This still evades America's main medical problem—the care of the long-term patient, the patient whom we so casually categorize as chronically ill, or in need of domiciliary care, and the patient whom we have relegated to what we think of as a secondary level of care in a separate institution. Dr. Bluestone (1) has pointed out many times, and so have many others, that patients cannot be artificially categorized as acute, chronic, or domiciliary, but that they change rapidly back and forth among these categories—or they can, if given adequate and competent care.

The use of the word "rehabilitation" is becoming a fad today, but certainly few if any communities can afford the financial luxury of providing life-long nursing home care to an increasing number of aging patients who, if treated early and adequately, can be taken out of an institution and restored to a useful measure of economic and social life within the community.

On the other hand, Dr. Bluestone has pointed out that whenever we successfully add a hospital facility within a custodial institution in order to perform this necessary rehabilitation function, we will find that we have added another general hospital to the community. To avoid such an eventuality, and to assure the most efficient and most economical level of patient care, all hospitals should be geared to the care of the long-term patient.

#### Coordination of Services

Use of the general hospital and of the home, together with home medical care to fill any gaps in care, plus the use of substitute homes when necessary, will provide an integrated program that will be better and cheaper in the long run than a multiplicity of uncoordinated facilities and services in the community.

The late Professor C-E. A. Winslow (2), the dean of public health, said: "Proper integration of hospital and chronic services with provision for home care and with public health is vital." Dr. Breslow (3) has stressed the importance of this coordination and has pointed out how difficult this task will be, particularly because of the deeply entrenched patterns for provision of care that already exist.

#### External Factors

Now let us look at some of the external factors that influence hospital care—factors over which the hospital has absolutely no control, but which will have a direct or indirect effect on its program.

**1. The Population Shift:** The slowest-growing group will be that one between the ages of 25 and 64—the segment which bears the major responsibility for maintenance of families. It is estimated that this group will grow from 81 million in 1956 to 96 million by 1975, a growth of slightly less than 20 percent. The population under 18 will increase by about 20 million, or roughly 35 percent. By 1975 it is estimated there will be 22 million people aged 65 and over, compared with the 14.5 million in 1956. This represents an increase of 7.5 million persons in this age group, or 52 percent.

These figures have some important implications for all of us:

- (a) A smaller portion of the population will be earning the money with which to pay hospital bills.
- (b) There will be an increase in the number of births in hospitals, and therefore of expenses for deliveries.
- (c) Unless some realistic program for financing the care of the aged is put into effect shortly, the problems we now have concerning the care of the aged will be even more acute.

While it can be argued that the larger proportion of younger and healthier people will reduce the needs for hospitalization, the figures on the needs of the aged indicate that the latter group will more than offset any gains.

In this connection, a report made by the Blue Cross Commission in 1957 (4) states that "the excess cost for ages 65 and over measured in days of hospitalization would be most probably somewhere between 2.5 and 3.0 days per year per person. This is equivalent to saying that the cost of hospitalization of persons 65 and over is from three to four times that for those under age 65." These data are supported by other studies.

Another significant fact, uncovered by the Metropolitan Life Insurance Company, is that the rate of usage for the upper middle-aged is apparently

not very much less than it is for the aged. We have traditionally used "age 65" as a dividing line, while apparently it should be realistically thought of more as a point of the upward curve of hospital usage.

At any rate, it is obvious that the population shift will be translated into a greater utilization of hospitals, and, therefore, increased expenses for hospital care.

**2. The Urban-Rural Shift: Working Wives and Smaller Homes:** A survey made in 1956 by the Bureau of the Census showed that the number of working wives had increased by about five million, or almost two-thirds, in the preceding ten years. The era of the housemaid has practically vanished, and less and less frequently is there someone who can stay home to take care of the person who is sick. Houses are smaller, so there is less often either a possibility or a willingness for a family to take in and care for an ill relative. From the standpoint of the family, it is more reasonable for the patient to be hospitalized, providing funds are available to pay the bill.

If this is related to the increase in the older age group, and to the inevitable corresponding increase in chronic disease, we can see how urgent it is to devise some means of providing medical care to this group, other than in institutions.

Another fact that contributes to the increased use of hospitals is the shift of the population from the rural to the urban centers of population. The availability of hospitals, and the greater hazards of city living, undoubtedly contribute to the greater use of hospitals by the urban dweller.

**3. The Effects of a Higher Educational Level and its Product—a More Sophisticated Public:** Studies have shown that the level of education of the individual has a direct influence on his readiness to be hospitalized. The average education of all adults in the nation has risen from nine years in 1950 to ten and one-half years in 1957, while the number of college graduates increased by 32 percent. To meet the demands of industry and society for a better-educated level of personnel, our colleges and universities are preparing to enroll more than double the number of students by 1970. It is safe to predict that this development will of itself result in an increased demand for,

and use of, hospital facilities in particular, and medical care generally.

Interestingly enough, the level of sophistication of the public is yet another external influence on the utilization of hospitals, and therefore of hospital costs. The various communications media—the press, television and radio—have discovered the curiosity of the public in regard to medicine and medical care, and it is difficult to come in contact with any of these media without learning about some new drug, or discovery, or controversy related to medicine.

The standard of living has been rising fairly steadily for a relatively long period of time, and the public has incorporated adequate hospital care as a usual and expected part of living. This requires that some hospitals provide facilities comparable to the best hotels, much to their consternation. "The effect on the patient's recovery is debatable, but the effect on the hospital's unit cost is significant." (5)

**4. Trends in Mortality and Morbidity:** This external influence is perhaps the most fascinating one to speculate on, because it bears within itself the seeds of the future growth and emphasis of the hospital field.

There have been radical changes in the past 50 years in the incidence of the diseases and conditions for which patients have been hospitalized. There has been a 46 percent reduction in the mortality rate and an increase in average life expectancy to nearly 70 years.

One of the more recent worries in the hospital world is the accentuation of the problems of staphylococcal infection, to which the uncritical use of antibiotics has probably contributed. To combat this, we are now forced to adjust our medical and nursing techniques and our ideas about isolation in general hospitals. Unexpected additional costs are involved, such as increased laundry expenses to assure the sterility of linens.

The most marked change in the past ten years has been the fall in tuberculosis mortality, which presages the end of a special institution for the diagnosis and treatment of this disease. On the other hand, chronic bronchitis is taking an increasing toll of human life, and it will occupy the attention of chest physicians to an increasing extent in the future.

General medicine has gained from the introduction of powerful thera-

peutic agents: the antibiotics, anticoagulants and steroid compounds. Although of inestimable value, the use of such drugs has frequently increased the load on hospital staffs, for the fact that they are powerful agents calls for careful clinical and laboratory control of their use. Interestingly enough, chemotherapy has reduced the need for some surgery, especially in the ear, nose and throat conditions, and it is altogether possible that other surgical procedures may give way eventually to drug therapy.

Certain other surgical procedures have increased, as, for example, heart surgery, aided by the development of modern anesthesia; and eye surgery—this being due partly to the need for treatment of older people with cataracts, and partly to the better diagnosis of visual defects in school children.

Along with the steady fall in infant mortality, and the use of drugs, fewer children appear to need admission to the hospital; but, almost as though there is a natural law of balance involved, reduced costs in this direction are being offset by the newer and more expensive ideas about the psy-

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Entered as second-class matter Jan. 25, 1949, at the Post Office at Berkeley, California, under the Act of Aug. 24, 1912. Acceptance for mailing at the special rate approved for in Section 1103, Act of Oct. 3, 1917.



chological and emotional effect of hospitalization on children.

The realm of the chronic sick has been referred to several times, and implicit in adequate care here is earlier medical treatment and active rehabilitation to reduce the number of days which patients need to spend in the hospital. This in turn is dependent on the development of one of the newer specialties—physical medicine—which is concerned with the early rehabilitation of patients. More attention will be paid to the somewhat large space requirements of physical medicine, because around this will be built the day hospital of the future—a relatively new concept that involves the attendance of patients at the hospital for observation, care and treatment during the day, returning home at the end of the day and for weekends.

Radiotherapy is making rapid advances, as is pathology, and the use of the general hospital for psychiatry. Great advances are taking place in the treatment of rheumatic and neurological conditions and in the field of plastic surgery.

As a matter of fact, we are on the verge of explosive developments in medical care, which may come so fast in the next ten years as to make the last decade or two, with all their innovations in medical care, look rather like the dark ages of medicine. Most of these changes will call for special consideration and planning and will require that the hospital change its role to provide the new services needed.

**5. Coordination of Facilities:** The impact of the changes referred to above should give added impetus to the far-too-slow acceptance of the need for coordinated regional planning of hospitals. We are rapidly approaching a time when it will no longer be economically feasible or practical for each hospital to be an independent, self-sufficient enterprise, purchasing equipment for its own use without regard to the needs of the community. For example, in the San Francisco Bay area there are at least five hospitals that are approved for open-heart surgery—a complicated and expensive facility to install and operate. Other hospitals are in the process of attempting to gain approval, yet to meet the needs of the area, three facilities would probably be sufficient.

Similarly, there are at least six, and probably more, electroencephalograph machines in use in San Francisco, of which not more than one or two are fully utilized. At the present time, several hospitals are considering the use of cobalt units—at \$60,000 per unit. How many of these does San Francisco need?

The planning of facilities on a coordinated regional basis is one of the most fertile areas for cost reductions; but unfortunately it is one of the most difficult to achieve, involving as it does the autonomy of individual Boards of Directors, medical staffs and hospital administrations, each with its own vested interests, its own philosophy, and its own desires.

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### Fluoridation Will Reappear On Ballot in Marin County

In the Marin Municipal Water District in Marin County, volunteers have obtained more than 10,500 signatures on a petition to place fluoridation on the ballot during the general election November 8, 1960. Fluoridation was voted down in that water district last June 7 by only 84 votes.

Mrs. William Loran, Mill Valley, chairman of the Marin Children's Dental Health Committee, organized the four-week campaign to obtain the necessary signatures. It was necessary to obtain signatures of 15 percent of the 54,000 registered voters in the water district in order to place the issue on the ballot in November. More than 500 volunteers participated, and more than enough names were collected.

The Children's Dental Health Committee has been in existence as a community group in Marin County since 1950. It is supported by the usual fund raising activities such as rummage sales, and by private donations.

### Staff Employed for Nurse Obstetric Assistant Project

Miss Sally Ann Yoemans and Mrs. Armentia Jarrett, both graduates of the Yale University Midwifery Program, have been employed as nurse obstetric assistants in the Madera County project on the use of nurse obstetric assistants in a rural county hospital maternity and newborn program (California's Health, July 15, 1960). Mrs. Jarrett is a PHN and Miss Yoemans is an RN; each has a master of science degree from Yale.

Pediatric, obstetric, and nurse-midwifery consultants have also been obtained for the project.

The program proposes to demonstrate the feasibility of using nurse obstetric assistants in order to improve the quality of care and ultimately to reduce the morbidity and mortality of mothers and babies when deliveries are in a rural county hospital. As far as is known, this is the first project of its kind in the United States.

Funds were granted for the project to begin July 1, 1960. Since that time staff have been recruited and employed and are now being oriented to the hospital and health department facilities. Detailed plans are being made and the project will actually get underway by January 1, 1961.

Specific objectives are to determine whether the nursing care of mothers and babies in the hospital will be improved by the supervision of the obstetric assistants, whether the program will be accepted by the community, whether the cost of such a service is practical, and whether continuity of nursing care will be improved by over-all planning for patient care and liaison activities with public health nurses in the health department.

In addition, the project will seek to determine whether the expectant mothers come earlier for care than previously, and whether they then continue with their care more consistently.

The latest official reports show that 30 states presently have atomic energy co-ordinators or advisory committees, or both, and 17 others have radiation committees advisory to the state health agencies.—*USPHS News Release* (8-60).

## Polio Advisory Committees Being Formed

The California State Board of Public Health has approved the reactivation of the State Health Department's Ad Hoc Advisory Committee for Prophylaxis of Poliomyelitis in order to aid the department in dealing with the introduction into California of the new live polio virus vaccine, as well as its proper integration into the existing poliomyelitis control program.

This committee was first organized in 1953 to advise the department about problems pertaining to the control of poliomyelitis in the State. The committee served through the mass field trials of gamma globulin as a prophylactic agent and the subsequent introduction of Salk vaccine and its attendant problems; it was then dissolved in February 1959.

Members of the present committee, some of whom served before, were appointed at the October 14th State Board of Public Health meeting in Los Angeles. They are: *John Adams, M.D.*, Professor of Pediatrics, School of Medicine, University of California, Los Angeles; *J. B. Askeu, M.D.*, San Diego County Health Officer, San Diego; *Herbert Bauer, M.D.*, Yolo County Health Officer, Woodland; *John M. Chapman, M.D.*, Professor of Epidemiology, School of Public Health, University of California, Los Angeles; *Irving J. Gordon, M.D.*, Professor and Chairman, Department of Medical Microbiology, University of Southern California, Los Angeles; *K. F. Meyer, M.D.*, Director Emeritus, George Williams Hooper Foundation, University of California Medical Center, San Francisco; *Edward B. Shaw, M.D.*, Professor of Pediatrics, U.C. Medical Center, San Francisco; *Lowell A. Rantz, M.D.*, Professor of Medicine, Stanford University School of Medicine, Palo Alto; *Robert Ward, M.D.*, Physician-in-Chief, Children's Hospital of Los Angeles, Los Angeles; *James L. Dennis, M.D.*, Medical Director, Children's Hospital of the East Bay, Oakland. Other members will probably be added to the committee later.

The State Department of Public Health will call the first meeting sometime this fall.

The United States Public Health Service has also announced the formation of a nationwide Committee on

## Poliomyelitis in California—January 1 to October 1, 1960

### Current Situation in California

The reported incidence of paralytic poliomyelitis has shown a generally declining trend since a high of 25 cases was reported during the third week of August 1960. Although it is not possible to predict with complete certainty the pattern of poliomyelitis, it would appear that this week might well be the peak week for the 1960 season.

During the first nine months of 1960 a total of 309 paralytic cases have been reported. During the comparable period in 1959, a total of 273 cases were reported. This slight increase in reported cases during the current year as compared to last year is almost entirely accounted for during the five weeks between June 12 and July 16. There was an early accumulation of cases during this period, forming a hump in reported incidence prior to the late August peak which is more typical of poliomyelitis in California.

Forty-five of the 63 cases reported during the five weeks between June 12 and July 16 were from Los Angeles, Orange, and San Diego Counties. Although no major concentrations of cases were noted in any particular neighborhoods or communities, it appears that the majority of

these cases occurred among unvaccinated persons in the lower socioeconomic areas.

### Age and Vaccination Status

The table shows the distribution by age and number of doses of Salk vaccine of the 289 cases of paralytic poliomyelitis occurring in California since January 1, for which individual case reports have been received. Of the total 289 cases, 40 percent were in children under five years of age, 30 percent were in children 5-14 years of age, and 30 percent were in persons over 15 years of age. The distribution of total cases by vaccination status has remained relatively unchanged during recent months. Eighty percent of the 289 cases had not received the recommended initial series of three inoculations, and 54 percent had never been inoculated.

### Poliomyelitis Fatalities

As of October 1, 1960, a total of 18 poliomyelitis deaths have been recorded, with a case fatality rate of 6 percent, which is well within the usual range. Only one of those who died was reported to have had three doses of vaccine, the last inoculation having been received three years ago. Twelve of the 18 fatal cases had never had any vaccine at all.

PARALYTIC POLIOMYELITIS BY AGE AND VACCINATION STATUS  
CALIFORNIA, JANUARY 1-OCTOBER 1, 1960

AGE GROUP	TOTAL CASES		VACCINATION STATUS				
	Number	Percent	No vaccine	1 dose	2 doses	3 doses	4+ doses
Total.....	289	100	155	40	36	43	15
0-4.....	117	40	70	13	16	15	3
5-9.....	75	26	26	14	13	16	6
10-14.....	11	4	1	2	1	6	1
15-19.....	9	3	3	3	2	1	--
20-24.....	16	6	12	1	3	--	--
25-29.....	25	9	16	4	--	4	1
30-34.....	18	6	14	1	1	--	2
35-39.....	11	4	6	2	--	1	2
40+.....	7	2	7	--	--	--	--

Poliomyelitis Control which will be made up of representatives of the medical and health professions and the general public. The surgeon general has issued invitations to the heads of twenty-three organizations asking them to designate members to serve on this committee.

An agenda committee has also been formed, made up of representatives of the American Academy of Pediatrics, the American Academy of Gen-

eral Practice, the American Medical Association, the Association of State and Territorial Health Officers, the Children's Bureau, and the National Foundation. The agenda committee met in October to develop the basic agenda for the first meeting of the Committee on Poliomyelitis Control.

In addition, the surgeon general has invited a number of experts in the field of polio vaccines to serve as consultants to the two committees.

## State-Federal Funds Allocated For Hospital Construction

State and federal matching funds totaling \$16,637,248 were allocated for the construction of California hospitals, public health centers, and related health facilities at the October 6-7 San Francisco meeting of the State Department of Public Health's Advisory Hospital Council.

The funds were allocated on a basis of priority need throughout the State after public hearings at which 75 applicants for funds had opportunity to present supporting information on their requests for grants. Applications were filed for facilities costing a total of \$112,600,000, but funds were only sufficient to provide approximately two-thirds financing for twenty-four of the projects. Applicants will provide the remaining one-third of the cost.

Funds were allotted as follows—

**General Hospitals:** *Needles Municipal Hospital*, Needles (12 beds), \$145,200; *Roseville District Hospital*, Roseville (54 beds), \$1,050,000; *Lake Tahoe Community Hospital*, Al Tahoe (38 beds), \$598,010; *Palo Verde Hospital*, Blythe (14 beds), \$520,000; *Barstow Community Hospital*, Barstow (14 beds), \$206,570; *Victor Valley Lutheran Hospital*, Victorville (54 beds), \$829,288; *St. Joseph Hospital*, Orange (135 beds), \$4,114,600; *Seaside Hospital*, Crescent City (26 beds), \$498,882; *Trinity General Hospital*, Weaverville (13 beds), \$230,476.

**General and Psychiatric Hospitals:** *San Antonio Community Hospital*, Upland (162 beds), \$2,580,400.

**Psychiatric Hospitals:** *Glendale Sanitarium and Hospital*, Glendale (60 beds), \$671,780; *Vista Hill Psychiatric Foundation*, San Diego (50 beds), \$856,422.

**Health Centers:** *Butte County Health Center*, Chico, \$151,270; *Sacramento County Health Center*, Sacramento, \$630,948; *South District Health Center*, Los Angeles, \$100,200; *San Joaquin District Health Center*, Stockton, \$379,244; *Eureka - Noe Health Center*, San Francisco, \$124,380.

**Nursing Homes:** *Rancho Los Amigos Hospital*, Downey (130 beds), \$1,242,080; *Holy Cross Hospital*, San Fernando (50 beds), \$335,568.

**Diagnostic and Treatment Centers:** *Santa Clara County Hospital*, San Jose, \$501,760; *Children's Hospital of East Bay*, Oakland, \$47,132.

## State Health Department States Position on Flu Vaccine

Routine annual immunization against influenza has been endorsed by the State Department of Public Health for Californians over the age of 65, pregnant women, and persons of all ages who suffer from chronic debilitating diseases. The Department endorses the specific recommendations recently made by the Public Health Service Advisory Committee on Influenza Research for immunization of these high risk groups.

During the influenza epidemic in the first quarter of this year approximately 3,000 more deaths from all causes were recorded in the State than were expected on the basis of experience of previous years. About 1,000 of these deaths were directly due to influenza and pneumonia, and these diseases undoubtedly were contributing factors in many of the other deaths. Almost 90 percent of these 3,000 "excess" deaths were in persons over the age of 65. These California data are in line with mortality experience in the rest of the nation.

In the past, influenza programs have tended to be intermittent, predominately in response to public concern before and during epidemic periods. Such epidemics tend to recur in unpredictable cycles, but an endemic incidence of influenza occurs continually.

Influenza may not be more likely to attack persons in the high risk groups specified above, but the occurrence in these persons is more likely to be a threat to life. For this reason, immunization of these groups is recommended to begin now and be continued annually, regardless of the predicted incidence of flu for a particular year. Two doses given two months apart are recommended for the initial immunization, followed by a booster dose each fall. A more detailed account of these recommendations has been distributed to local health officers.

Physicians are urged to make influenza vaccination for the aged and chronically ill as routine a medical practice as is the immunization of infants against diphtheria or pertussis.

**Rehabilitation Facilities:** *Los Angeles County General Hospital*, Los Angeles, \$705,934; *Research and Rehabilitation Center of San Mateo County*, Burlingame, \$117,104.

## Foreign Visitors

In recent months the California State Department of Public Health has arranged observation training programs for prominent public health and medical specialists from more than ten countries. Among the more recent distinguished visitors were:

Iran—*Dr. Hassan Ali Azarakhsh*, Director General, Narcotics Control Administration, Teheran.

Iran—*Dr. Faziollah Motazedi*, Permanent Undersecretary to the Ministry of Health, Government of Iran, Teheran, Iran.

South Viet-Nam—*Dr. Nguyen Duc Nguyen*, Project Manager for the "Medical Center" Project, University of Saigon, Saigon, South Viet-Nam.

United Arab Republic—*Dr. Bashir El-Asma*, Central Minister of Health, United Arab Republic.

United Arab Republic—*Dr. Mohammed Fakhr Sobky*, Director, Malaria Section, Endemic Diseases Department, Ministry of Health, Cairo, Egypt, United Arab Republic.

New Zealand—*Colin Alfred Cowie*, Engineer, Public Health Engineering Section, Office of Chief Designing Engineering, Ministry of Works, Wellington.

Argentina—*Oscar Enrique Paitovi*, Department Chief, chief design engineer for water works for all of Argentina, Buenos Aires.

Argentina—*Arnaldo Tolstet Stabile*, Department Chief, chief design engineer for sewerage and sewage treatment for all of Argentina, Buenos Aires.

Afghanistan—*Dr. Syed Hashmattullah*.

Japan—*Dr. Yoshio Ikeda*, Chief, Pharmacological Division, National Hygienic Laboratory, Ministry of Health and Welfare, Tokyo.

Belgium—*Gaston Varenne*, Assistant in Neuropsychiatric Service, Faculty of Medicine, University of Ghent.

Peru—*Dr. Darwin Del Castillo*, Head of Dental Services, Health Unit, Chimbote.

Chile—*Dr. Jose Manuel D. Borgono*, Doctor-Professor, Servicio Nacional De Salud, Santiago, Chile.

Orphanhood is fast diminishing as a social problem \* \* \* factors have been the decline in full orphans, the increased placement of orphaned children under adoption procedures and into foster homes, and the growth of public income-maintenance programs, which enable many widows to keep their children at home.—*Progress in Health Service*, Volume VII, No. 7.

By far the most extensive trials of live polio virus vaccines are those in progress in the U.S.S.R., where the number of children vaccinated with the strains developed by Dr. Albert Sabin now exceeds 6 million.—*WHO Chronicle*, Vol. 13, No. 12.



## REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF SEPTEMBER 1960

Disease	Cases reported this month			Total cases reported to date		
	1960	1959	1958	1960	1959	1958
<b>Series A: By Place of Report</b>						
Amebiasis	35	64	24	358	487	863
Coccidioidomycosis	14	21	12	172	194	148
Measles	204	307	312	21,191	39,257	33,276
Meningococcal infections	14	13	18	157	159	148
Mumps	792	531	397	19,423	9,940	14,419
Pertussis	209	283	319	1,467	1,983	3,093
Rheumatic fever	5	13	10	114	113	109
Salmonellosis	101	112	104	947	874	763
Shigellosis	159	360	234	1,516	1,507	1,291
Streptococcal infections, respiratory	1,475	1,525	618	23,344	16,739	10,177
Trachoma	3	2	--	91	23	2
<b>Series B: By Place of Residence</b>						
Chancroid	10	10	6	93	57	68
Conjunctivitis, acute newborn	--	1	2	12	5	14
Gonococcal infections	1,469	1,740	1,422	14,004	12,798	12,750
Granuloma inguinale	--	--	2	10	1	8
Lymphogranuloma venereum	--	--	1	24	15	24
Syphilis, total	530	598	434	5,896	5,206	4,600
Primary and secondary	110	99	70	1,166	802	418
<b>Series C: By Place of Contraction</b>						
Botulism	--	--	--	--	2	1
Brucellosis	3	1	4	16	10	28
Diarrhea of the newborn	--	14	1	6	54	17
Diphtheria	--	1	--	--	5	5
Encephalitis	32	36	74	419	303	445
Food poisoning (exclude botulism)	161	268	78	1,254	1,268	842
Hepatitis, infectious	422	246	149	3,412	1,936	1,468
Hepatitis, serum	16	5	12	97	66	89
Leprosy	--	3	1	7	14	10
Leptospirosis	--	1	--	1	3	2
Malaria	3	3	2	11	23	15
Meningitis, viral or aseptic	103	196	259	539	668	594
Plague	--	--	--	--	2	--
Poliomyelitis, total	72	97	48	354	323	192
Paralytic	62	85	40	309	273	130
Nonparalytic	10	12	8	45	50	62
Psittacosis	--	1	--	11	14	15
Q fever	1	6	3	30	53	32
Rabies, animal	10	12	9	97	100	139
Rabies, human	--	--	--	--	1	--
Relapsing fever (tick borne)	1	3	--	6	3	--
Rocky Mountain spotted fever	--	1	--	2	3	--
Tetanus	3	2	3	26	32	36
Trichinosis	1	1	--	3	5	4
Tularemia	1	--	--	3	4	3
Typhoid fever	10	7	4	42	58	42
Typhus fever (endemic)	--	--	1	--	3	3
Other*	--	--	--	--	--	--
Tuberculosis <sup>1</sup>	--	--	--	3,929	3,990	4,548

\* This space will be used for any of the following rare diseases if reported: Anthrax, Cholera, Dengue, Relapsing Fever (louse borne), Smallpox, Typhus Fever (epidemic), Yellow Fever.

<sup>1</sup> Tuberculosis cases are corrected to exclude out of state residents and changes in diagnosis; monthly figures not published.

## Index to California's Health Available for 1959-1960

The index to Volume 17 (July, 1959 - June, 1960) of *California's Health* is now available. Copies have been sent to all health officers and health educators in local health departments in the State, and to bureau and division chiefs in the State Department of Public Health. Others who wish copies may obtain them from the Bureau of Health Education, California State Department of Public Health, 2151 Berkeley Way, Berkeley 4, California.

### MEETINGS SCHEDULED

Oct. 30-Nov. 4—American School Health Assn., Annual Meeting, San Francisco

Oct. 31-Nov. 3—National Citizens Committee for the WHO, San Francisco

Oct. 31-Nov. 4—American Public Health Assn., 88th Annual Meeting, San Francisco

Nov. 2-5—American Speech and Hearing Assn., Los Angeles

Nov. 14-18—American Occupational Therapy Assn., Annual Conference, Los Angeles

Dec. 3-6—Conference of Rehabilitation Centers and Facilities, Berkeley

## Public Health Positions

### Fresno County

**Assistant Director Public Nursing:** Salary range, \$503-\$629. Seeking experienced, creative PHN to develop and implement training program in Fresno—city of 134,000, county of 360,000, midway between San Francisco and Los Angeles. Position requires a master's degree in public health nursing administration from a university program approved by NLN or an MPH from a university program approved by the AHPA, plus four years of progressively responsible PHN experience including two years in a supervisory capacity. Must have valid California PHN certificate or obtain it during probationary period.

**Crippled Children Services Supervisor:** Salary range, \$503-\$629. To supervise crippled and handicapped children's service unit in Fresno—midway between San Francisco and Los Angeles, near mountains and ocean. Requires MSW with specialization in medical, psychiatric or rehabilitation case work (or a closely related specialty) or college graduation and two years social case work, one year in a supervisory capacity. Written exam may be taken in your area.

For either position, apply by December 2, 1960 to Edward W. Firby, Director of Personnel, Fresno County Civil Service, Hall of Records, Fresno, California.

### Humboldt-Del Norte County

**Director of Public Health Nursing:** Salary range, \$519-\$649; starting level negotiable and automatic step increase after first six months. Generalized program in semirural bi-county jurisdiction in Redwood Empire on Pacific Coast serving population of 125,000. California PHN certification and administrative experience required for director. Nursing staff of 15 including supervisor. Work week is 37½ hours.

**Public Health Nurse:** Salary range, \$439-\$549; advance to second step after six months; county car furnished. Generalized program, including school nursing. Requires California PHN certificate.

Apply to L. S. McLean, M.D., M.P.H., Health Officer, Humboldt-Del Norte County Health Department, 805 Sixth Street, Eureka, California.

### Los Angeles City

**Principal Public Health Statistician:** Salary range, \$641-\$797. Four years of professional experience in public health statistical analysis is required.

**Industrial Hygiene Chemist:** Salary range, \$608-\$755. Three years of professional experience in inorganic and organic physical chemistry and in radiological assay work is required.

**Radiological Health Technician:** Salary range, \$575-\$715. Two years of professional experience is required in radiological safety work or in occupational health, including work in a radiological health program.

University graduation required for all positions. Write to George M. Uhl, M.D., Health Officer, Los Angeles City Health Department, 111 East First Street, Los Angeles 12, California.

### Monterey County

**Public Health Nursing Supervisor:** Salary range, \$470 to \$583. Automatic step increase after first 6 months. To supervise in a gen-

eralized program including some school nursing. Requirements include two years experience in public health nursing, and California public health nurse certification or eligibility therefor. Generous retirement plan, 3 weeks vacation and 3 weeks sick leave accumulated annually. Voluntary participation in group health insurance program with county paying a portion of premium. Please contact Myron W. Husband, M.D., Health Officer, Monterey County Health Department, 154 West Alisal Street, Salinas, California.

#### San Bernardino County

**Supervising Public Health Nurse:** Salary range, \$489 to \$608, if candidate has master's degree in public health nursing and two years' public health nursing experience. Candidate with a bachelor's degree starts at \$464 with step increases to \$575.

**Medical Social Work Consultant:** Salary range, \$545 to \$608. Completion of two-year, post-graduate social work course and either one year's experience in a hospital, clinic, or health department or two years' medical or psychiatric social work experience.

**Dairy Inspector:** Salary range, \$417 to \$516. Must be registered or eligible for State registration.

All positions covered by retirement plan, Social Security, sick leave, medical plan, paid holidays and mileage reimbursement. Apply to Department of Civil Service and Personnel, Courthouse Addition, San Bernardino, California.

#### San Diego County

**Health Educator:** Salary range, \$587 to \$647. To share with Department staff and community groups the responsibility for planning public health education programs and in-service education activities. Must have MPH degree in public health education or be within three months of obtaining degree. One year's health education experience required. The year may include three months supervised field work in an official public health department.

**Occupational Therapist:** Salary range, \$424 to \$515. To work with physically handicapped children in elementary schools. Grad-

uation from a recognized school of occupational therapy required, plus at least one year of supervised experience. Experience in treating children with cerebral palsy preferred. Membership in National Registry of Qualified Occupational Therapists required before permanent appointment.

Health Department offices in beautiful new building near Civic Center. For further information about either of these positions write to the Department of Civil Service and Personnel, Room 403, Civic Center, San Diego, California.

#### San Joaquin Local Health District

**Assistant Health Officer I:** Salary range, \$944-\$1147. Two positions: Director of Maternal and Child Health, and Director of School Health. Both positions require California license, plus MPH or residency training in pediatrics. Starting salary may be set above first step. Car furnished; 40 hour week. Employee benefits include: retirement plan; 15 days vacation; 12 days sick leave, cumulative to 90 days, convertible to additional vacation time after maximum reached; employer participation in medical and hospitalization plan.

Further information may be obtained from Jack J. Williams, M.D., Health Officer, San Joaquin Local Health District, P.O. Box 2009, Stockton, California.

#### Sonoma County

**Public Health Nurse:** Salary range effective January 1, 1961, \$429-\$515. Excellent working conditions, 15 days annual vacation and twelve days sick leave. Requires California RN and PHN certificates. For more information write to Sonoma County Personnel Office, 2555 Mendocino Avenue, Santa Rosa, California.

The over-65 population (of the U.S.) has two to three times as much chronic illness as the rest of the population.—*Fact Sheet on Health Services for the Aged*, U.S. Senate Subcommittee on Problems of the Aged and Aging.

## Personals

**Robert Dyar, M.D.**, Chief of the Division of Research, State Department of Public Health, has been appointed to serve a four-year term as chairman of the Advisory Committee on Epidemiology and Biometry of the National Institutes of Health, U.S. Public Health Service. He will direct the review of applications for Public Health Service training grants in the fields of epidemiology and biometry.

**Antoinette Harris**, Maternal Health Nursing Consultant, has resigned after more than seven years with the State Department of Public Health. She is interested in nursing research and will continue graduate study at the School of Nursing, University of Washington, Seattle. Miss Harris received her master of science degree in 1955 from the School of Nursing, University of California.

By 1970, Dr. Burney reported, federal, state, and local health agencies, industry, hospitals, and universities will need at least 4,000 additional physicians, engineers, and physicists with extensive training in radiological health and protection measures. To reach this number, the nation's colleges and universities should be admitting annually at least 600 candidates for such training. The Surgeon General said that only about 200 were currently being given such training each year.—*USPHS News Release* (8-60).

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